

(F) Any concerns the actuary has with the risk adjustment process.

(ii) All retrospective risk adjustment methodologies must be adequately described with enough detail so that CMS or an actuary applying generally accepted actuarial principles and practices can understand and evaluate the following:

(A) The party calculating the risk adjustment.

(B) The data, and any adjustments to that data, to be used to calculate the adjustment.

(C) The model, and any adjustments to that model, to be used to calculate the adjustment.

(D) The timing and frequency of the application of the risk adjustment.

(E) Any concerns the actuary has with the risk adjustment process.

(iii) Application of an approved risk adjustment methodology to capitation rates does not require a revised rate certification because payment of capitation rates as modified by the approved risk adjustment methodology must be within the scope of the original rate certification. The State must provide to CMS the payment terms updated by the application of the risk adjustment methodology consistent with § 438.3(c).

(6) *Special contract provisions.* A description of any of the special contract provisions related to payment in § 438.6 that are applied in the contract.

(c) *Rates paid under risk contracts.* The State, through its actuary, must certify the final capitation rate paid per rate cell under each risk contract and document the underlying data, assumptions and methodologies supporting that specific capitation rate.

(1) The State may pay each MCO, PIHP or PAHP a capitation rate under the contract that is different than the capitation rate paid to another MCO, PIHP or PAHP, so long as each capitation rate per rate cell that is paid is independently developed and set in accordance with this part.

(2) If the State determines that a retroactive adjustment to the capitation rate is necessary, the retroactive adjustment must be supported by a rationale for the adjustment and the data, assumptions and methodologies used to develop the magnitude of the

adjustment must be adequately described with enough detail to allow CMS or an actuary to determine the reasonableness of the adjustment. These retroactive adjustments must be certified by an actuary in a revised rate certification and submitted as a contract amendment to be approved by CMS. All such adjustments are also subject to Federal timely claim filing requirements.

(3) The State may increase or decrease the capitation rate per rate cell, as required in paragraph (c) of this section and § 438.4(b)(4), up to 1.5 percent without submitting a revised rate certification, as required under paragraph (a) of this section. Such changes of the capitation rate within the permissible 1.5 percent range must be consistent with a modification of the contract as required in § 438.3(c).

(d) *Provision of additional information.* The State must, upon CMS' request, provide additional information, whether part of the rate certification or additional supplemental materials, if CMS determines that information is pertinent to the approval of the certification under this part. The State must identify whether the information provided in addition to the rate certification is proffered by the State, the actuary, or another party.

§ 438.8 Medical loss ratio (MLR) standards.

(a) *Basic rule.* The State must ensure, through its contracts starting on or after July 1, 2017, that each MCO, PIHP, and PAHP calculate and report a MLR in accordance with this section. For multi-year contracts that do not start in 2017, the State must require the MCO, PIHP, or PAHP to calculate and report a MLR for the rating period that begins in 2017.

(b) *Definitions.* As used in this section, the following terms have the indicated meanings:

Credibility adjustment means an adjustment to the MLR for a partially credible MCO, PIHP, or PAHP to account for a difference between the actual and target MLRs that may be due to random statistical variation.

Full credibility means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient

for the calculation of a MLR with a minimal chance that the difference between the actual and target medical loss ratio is not statistically significant. An MCO, PIHP, or PAHP that is assigned full credibility (or is fully credible) will not receive a credibility adjustment to its MLR.

Member months mean the number of months an enrollee or a group of enrollees is covered by an MCO, PIHP, or PAHP over a specified time period, such as a year.

MLR reporting year means a period of 12 months consistent with the rating period selected by the State.

No credibility means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be insufficient for the calculation of a MLR. An MCO, PIHP, or PAHP that is assigned no credibility (or is non-credible) will not be measured against any MLR requirements.

Non-claims costs means those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e)(2) of this section); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of this section); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of this section).

Partial credibility means a standard for which the experience of an MCO, PIHP, or PAHP is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. An MCO, PIHP, or PAHP that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.

(c) *MLR requirement.* If a State elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, that minimum MLR must be equal to or higher than 85 percent (the standard used for projecting actuarial soundness under § 438.4(b)) and the MLR must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP, consistent with this section.

(d) *Calculation of the MLR.* The MLR experienced for each MCO, PIHP, or PAHP in a MLR reporting year is the

ratio of the numerator (as defined in paragraph (e) of this section) to the denominator (as defined in paragraph (f) of this section). A MLR may be increased by a credibility adjustment, in accordance with paragraph (h) of this section.

(e) *Numerator*—(1) *Required elements.* The numerator of an MCO's, PIHP's, or PAHP's MLR for a MLR reporting year is the sum of the MCO's, PIHP's, or PAHP's incurred claims (as defined in (e)(2) of this section); the MCO's, PIHP's, or PAHP's expenditures for activities that improve health care quality (as defined in paragraph (e)(3) of this section); and fraud reduction activities (as defined in paragraph (e)(4) of this section).

(2) *Incurred claims.* (i) Incurred claims must include the following:

(A) Direct claims that the MCO, PIHP, or PAHP paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

(C) Withholds from payments made to network providers.

(D) Claims that are recoverable for anticipated coordination of benefits.

(E) Claims payments recoveries received as a result of subrogation.

(F) Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

(G) Changes in other claims-related reserves.

(H) Reserves for contingent benefits and the medical claim portion of lawsuits.

(ii) Amounts that must be deducted from incurred claims include the following:

(A) Overpayment recoveries received from network providers.

(B) Prescription drug rebates received and accrued.

(iii) Expenditures that must be included in incurred claims include the following:

(A) The amount of incentive and bonus payments made, or expected to be made, to network providers.

(B) The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph (e)(4) of this section.

(iv) Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

(v) Amounts that must be excluded from incurred claims:

(A) Non-claims costs, as defined in paragraph (b) of this section, which include the following:

(1) Amounts paid to third party vendors for secondary network savings.

(2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.

(3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

(4) Fines and penalties assessed by regulatory authorities.

(B) Amounts paid to the State as remittance under paragraph (j) of this section.

(C) Amounts paid to network providers under to § 438.6(d).

(vi) Incurred claims paid by one MCO, PIHP, or PAHP that is later assumed by another entity must be reported by the assuming MCO, PIHP, or PAHP for the entire MLR reporting year and no incurred claims for that MLR reporting year may be reported by the ceding MCO, PIHP, or PAHP.

(3) *Activities that improve health care quality.* Activities that improve health care quality must be in one of the following categories:

(i) An MCO, PIHP, or PAHP activity that meets the requirements of 45 CFR 158.150(b) and is not excluded under 45 CFR 158.150(c).

(ii) An MCO, PIHP, or PAHP activity related to any EQR-related activity as described in § 438.358(b) and (c).

(iii) Any MCO, PIHP, or PAHP expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims, as defined in paragraph (e)(2) of this section.

(4) *Fraud prevention activities.* MCO, PIHP, or PAHP expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.

(f) *Denominator—(1) Required elements.* The denominator of an MCO's, PIHP's, or PAHP's MLR for a MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the MCO's, PIHP's, or PAHP's premium revenue (as defined in paragraph (f)(2) of this section) minus the MCO's, PIHP's, or PAHP's Federal, State, and local taxes and licensing and regulatory fees (as defined in paragraph (f)(3) of this section) and is aggregated in accordance with paragraph (i) of this section.

(2) *Premium revenue.* Premium revenue includes the following for the MLR reporting year:

(i) State capitation payments, developed in accordance with § 438.4, to the MCO, PIHP, or PAHP for all enrollees under a risk contract approved under § 438.3(a), excluding payments made under to § 438.6(d).

(ii) State-developed one time payments, for specific life events of enrollees.

(iii) Other payments to the MCO, PIHP, or PAHP approved under § 438.6(b)(3).

(iv) Unpaid cost-sharing amounts that the MCO, PIHP, or PAHP could have collected from enrollees under the contract, except those amounts the MCO, PIHP, or PAHP can show it made a reasonable, but unsuccessful, effort to collect.

(v) All changes to unearned premium reserves.

(vi) Net payments or receipts related to risk sharing mechanisms developed in accordance with § 438.5 or § 438.6.

(3) *Federal, State, and local taxes and licensing and regulatory fees.* Taxes, licensing and regulatory fees for the MLR reporting year include:

(i) Statutory assessments to defray the operating expenses of any State or Federal department.

(ii) Examination fees in lieu of premium taxes as specified by State law.

(iii) Federal taxes and assessments allocated to MCOs, PIHPs, and PAHPs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

(iv) State and local taxes and assessments including:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

(B) Guaranty fund assessments.

(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

(v) Payments made by an MCO, PIHP, or PAHP that are otherwise exempt from Federal income taxes, for community benefit expenditures as defined in 45 CFR 158.162(c), limited to the highest of either:

(A) Three percent of earned premium; or

(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.

(4) *Denominator when MCO, PIHP, or PAHP is assumed.* The total amount of the denominator for a MCO, PIHP, or PAHP which is later assumed by another entity must be reported by the assuming MCO, PIHP, or PAHP for the entire MLR reporting year and no amount under this paragraph for that year may be reported by the ceding MCO, PIHP, or PAHP.

(g) *Allocation of expense*—(1) *General requirements.* (i) Each expense must be

included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

(2) *Methods used to allocate expenses.*

(i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(iii) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

(h) *Credibility adjustment.* (1) A MCO, PIHP, or PAHP may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible. The credibility adjustment is added to the reported MLR calculation before calculating any remittances, if required by the State as described in paragraph (j) of this section.

(2) A MCO, PIHP, or PAHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible.

(3) If a MCO's, PIHP's, or PAHP's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards in this section.

(4) On an annual basis, CMS will publish base credibility factors for MCOs, PIHPs, and PAHPs that are developed according to the following methodology:

(i) CMS will use the most recently available and complete managed care encounter data or FFS claims data, and enrollment data, reported by the states to CMS. This data may cover more than 1 year of experience.

(ii) CMS will calculate the credibility adjustment so that a MCO, PIHP, or PAHP receiving a capitation payment

that is estimated to have a medical loss ratio of 85 percent would be expected to experience a loss ratio less than 85 percent 1 out of every 4 years, or 25 percent of the time.

(iii) The minimum number of member months necessary for a MCO's, PIHP's, or PAHP's medical loss ratio to be determined at least partially credible will be set so that the credibility adjustment would not exceed 10 percent for any partially credible MCO, PIHP, or PAHP. Any MCO, PIHP, or PAHP with enrollment less than this number of member months will be determined non-credible.

(iv) The minimum number of member months necessary for an MCO's, PIHP's, or PAHP's medical loss ratio to be determined fully credible will be set so that the minimum credibility adjustment for any partially credible MCO, PIHP, or PAHP would be greater than 1 percent. Any MCO, PIHP, or PAHP with enrollment greater than this number of member months will be determined to be fully credible.

(v) A MCO, PIHP, or PAHP with a number of enrollee member months between the levels established for non-credible and fully credible plans will be deemed partially credible, and CMS will develop adjustments, using linear interpolation, based on the number of enrollee member months.

(vi) CMS may adjust the number of enrollee member months necessary for a MCO's, PIHP's, or PAHP's experience to be non-credible, partially credible, or fully credible so that the standards are rounded for the purposes of administrative simplification. The number of member months will be rounded to 1,000 or a different degree of rounding as appropriate to ensure that the credibility thresholds are consistent with the objectives of this regulation.

(i) *Aggregation of data.* MCOs, PIHPs, or PAHPs will aggregate data for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

(j) *Remittance to the State if specific MLR is not met.* If required by the State, a MCO, PIHP, or PAHP must provide a remittance for an MLR reporting year if the MLR for that MLR

reporting year does not meet the minimum MLR standard of 85 percent or higher if set by the State as described in paragraph (c) of this section.

(k) *Reporting requirements.* (1) The State, through its contracts, must require each MCO, PIHP, or PAHP to submit a report to the State that includes at least the following information for each MLR reporting year:

- (i) Total incurred claims.
 - (ii) Expenditures on quality improving activities.
 - (iii) Expenditures related to activities compliant with § 438.608(a)(1) through (5), (7), (8) and (b).
 - (iv) Non-claims costs.
 - (v) Premium revenue.
 - (vi) Taxes, licensing and regulatory fees.
 - (vii) Methodology(ies) for allocation of expenditures.
 - (viii) Any credibility adjustment applied.
 - (ix) The calculated MLR.
 - (x) Any remittance owed to the State, if applicable.
 - (xi) A comparison of the information reported in this paragraph with the audited financial report required under § 438.3(m).
 - (xii) A description of the aggregation method used under paragraph (i) of this section.
 - (xiii) The number of member months.
- (2) A MCO, PIHP, or PAHP must submit the report required in paragraph (k)(1) of this section in a timeframe and manner determined by the State, which must be within 12 months of the end of the MLR reporting year.

(3) MCOs, PIHPs, or PAHPs must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that MCO, PIHP, or PAHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCO, PIHP, or PAHP, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

(l) *Newer experience.* A State, in its discretion, may exclude a MCO, PIHP, or PAHP that is newly contracted with the State from the requirements in this section for the first year of the MCO's, PIHP's, or PAHP's operation.

§ 438.9

42 CFR Ch. IV (10–1–16 Edition)

Such MCOs, PIHPs, or PAHPs must be required to comply with the requirements in this section during the next MLR reporting year in which the MCO, PIHP, or PAHP is in business with the State, even if the first year was not a full 12 months.

(m) *Recalculation of MLR.* In any instance where a State makes a retroactive change to the capitation payments for a MLR reporting year where the report has already been submitted to the State, the MCO, PIHP, or PAHP must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in paragraph (k) of this section.

(n) *Attestation.* MCOs, PIHPs, and PAHPs must attest to the accuracy of the calculation of the MLR in accordance with requirements of this section when submitting the report required under paragraph (k) of this section.

§ 438.9 Provisions that apply to non-emergency medical transportation PAHPs.

(a) For purposes of this section, Non-Emergency Medical Transportation (NEMT) PAHP means an entity that provides only NEMT services to enrollees under contract with the State, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

(b) Unless listed in this paragraph (b), a requirement of this part does not apply to NEMT PAHPs, NEMT PAHP contracts, or States in connection with a NEMT PAHP. The following requirements and options apply to NEMT PAHPs, NEMT PAHP contracts, and States in connection with NEMT PAHPs, to the same extent that they apply to PAHPs, PAHP contracts, and States in connection with PAHPs.

(1) All contract provisions in § 438.3 except requirements for:

- (i) Physician incentive plans at § 438.3(i).
- (ii) Advance directives at § 438.3(j).
- (iii) LTSS requirements at § 438.3(o).
- (iv) MHPAEA at § 438.3(n).

(2) The actuarial soundness requirements in § 438.4.

(3) The information requirements in § 438.10.

(4) The provision against provider discrimination in § 438.12.

(5) The State responsibility provisions in §§ 438.56, 438.58, 438.60, 438.62(a), and 438.818.

(6) The provisions on enrollee rights and protections in subpart C of this part except for §§ 438.110 and 438.114.

(7) The PAHP standards in §§ 438.206(b)(1), 438.210, 438.214, 438.224, 438.230, and 438.242.

(8) An enrollee's right to a State fair hearing under subpart E of part 431 of this chapter.

(9) Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in § 438.610.

(10) Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in § 438.14.

§ 438.10 Information requirements.

(a) *Definitions.* As used in this section, the following terms have the indicated meanings:

Limited English proficient (LEP) means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

Prevalent means a non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

Readily accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(b) *Applicability.* The provisions of this section apply to all managed care programs which operate under any authority in the Act.

(c) *Basic rules.* (1) Each State, enrollment broker, MCO, PIHP, PAHP, PCCM, and PCCM entity must provide all required information in this section to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible